STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARE BRIDGE OF CARMEL LLC	301 EXECUTIVE DR CARMEL, IN 46032

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R0000	This visit was for a State Residential Licensure Survey. This visit included Investigation of Complaints IN00104417 and IN00104821. Complaint IN00104417 - Unsubstantiated due to lack of evidence. Complaint IN00104821 - Substantiated. No deficiencies related to the allegation are cited. Survey Dates: March 6, 7, and 8, 2012 Survey Team: Heather Lay, RN - TC Michelle Hosteter, RN Facility Number: 010416 Provider Number: 010416 AIM Number: N/A Census Bed Type: Residential: 65 Total: 65 Census Payor Type: Other: 65 Total: 65 Residential Sample: 8	R0000	**The following is the Plan of Correction for Clare Bridge of Carmel in regards to the Statement of Deficiencies for the annual and complaint survey completed on 3-8-2012. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These State Residential findings are cited in accordance with 410 IAC 16.2. Quality review completed 3/12/12 Cathy Emswiller RN			

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R0089	410 IAC 16.2-5-1.3(e)(1-2)(f) Administration and Management - Noncompliance (e) An administrator shall be employed to work in each licensed health facility. For purposes of this subsection, an individual can only be employed as an administrator in one (1): (1) health facility; or (2) hospital-based long-term care unit; at a time. (f) In the administrator's absence, an individual shall be authorized, in writing, to act on the administrator's behalf. Based on record review and interview, the facility failed to employ an Administrator. The deficient practice impacted the facility for five months and had the potential to affect 65 of 65 residents who resided in the facility. Findings include: On 3/6/12 at 10:15 A.M. during entrance conference, the entrance conference checklist items were requested from the Health and Wellness Director and the Regional Vice President. Those items included, but were not limited to, "List of key personnel by name, title, and their location and Policy on residential admittance and continued stay at residential level..." On 3/6/12 at 11:15 A.M., the Health and Wellness Director provided a document	R0089	**R 089 Administration and Management-Non-compliance** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · **The alleged non-compliant practice was cited as having the potential to impact all 65 residents who resided in the community · During the 5 month period that elapsed since the 10-17-2011 departure of the previous Administrator, the Executive Director from another Brookdale community nearby was assigned by the Regional Vice President to provide immediate oversight, while the recruiting process was initiated. · The person in charge of the community was designated as the Health and Wellness Director during the interim period. · An Executive Director Pro-Tem was put in**	04/07/2012

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	"Contact List." The "Contact List" included, but was not limited to, "Executive Director: [New Executive Director] to start on 4/10/12 Interim - [Name of Health and Wellness Director]. In an interview at that time with the Health and Wellness Director, she indicated the last Administrator left on October 17, 2011, and the facility had hired a new Executive Director who had not started yet. She also indicated she did not have a current Health Facility Administrator's license and was not currently enrolled in classes to obtain her Health Facility Administrator's license. The Health and Wellness Director indicated the Indiana State Department of Health was notified of the facility Administrator vacancy.		**place on a full-time basis effective November 5, 2011 through March 8 th , 2012 · The Indiana State Department of Health was notified via mail on 10-21-11 of all the above arrangements · An Executive Director has been hired and will start on April 10 th , 2012. The state was notified of this hire as well as the start date. This notification was sent via e-mail and dated 2-22-12 (prior to the survey).** ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** **· The alleged non-compliant practice had the potential to affect all residents of the community. · During the 5 month period that elapsed since the 10-17-2011 departure of the previous Administrator, the Executive Director from another Brookdale community nearby was assigned by the Regional Vice President to provide immediate oversight, while the recruiting process was initiated. · The person in charge of the community was designated as the Health and Wellness Director during the interim period. · An Executive Director Pro-Tem was put in place on a full-time basis effective November 5, 2011**	

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			through March 8 th , 2012 · The Indiana State Department of Health was notified via mail on 10-21-11 of all the above arrangements · An Executive Director has been hired and will start on April 10 th , 2012. The state was notified of this hire as well as the start date. This notification was sent via e-mail and dated 2-22-12 (prior to the survey). What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · The new Executive Director for the community will start on 4-10-12. · The community will notify the ISDH in the event of any changes in Executive Director within 3 days. · In the event of a future opening of the Administrator position, an interim will be designated and the ISDH will be notified. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? · The Regional Vice President will continue to provide operational oversight to this community on a weekly basis in order to support the new Executive Director. *By what date will these systemic changes be implemented?* · 4-7-12	

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R0095	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on record review and interview, the facility failed complete the "Alzheimer's/Dementia Special Care Unit" disclosure. The deficient practice impacted 65 of 65 residents who resided in the facility. Findings include: On 3/6/12 at 10:15 A.M. during entrance	R0095	**R 095 Administration and Management-Non-compliance** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · **On 3-7-12 at 9 am, the community's Regional Vice President provided the surveyors with a copy of the completed "Alzheimer's/Dementia Special Care Unit" disclosure dated 3-6-12. The survey reports this oversight had the potential to affect all 65 residents of**	04/07/2012

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	conference, items were requested from the "Entrance Conference Checklist" from the Health and Wellness Director and the Regional Vice President. On 3/6/12 at 11:15 A.M., the Health and Wellness Director provided the "Policy on residential admittance and continued stay a residential level" dated 7/2003. The policy included, but was not limited to, "The community may admit and retain adults who meet the following criteria: Can exhibit signs of confusion and forgetfulness, and behaviors..." At that time, during interview, the Regional Vice President and Health and Wellness Director indicated the facility is a "Memory Care" facility and all residents have a diagnosis of dementia. On 3/6/12 at 2:00 P.M. during daily exit conference, the facility "Alzheimer's/Dementia Special Care Unit" disclosure was requested. On 3/7/12 at 9:00 A.M., the facility Regional Vice President provided an "Alzheimer's/Dementia Special Care Unit" disclosure dated 3/6/12. The "Alzheimer's/Dementia Special Care Unit" dated 3/6/12 included, but was not limited to, "Is the unit locked...yes, Does		**the community.** ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** **· The appropriate documentation was immediately completed and provided to the surveyors on 3-7-12.** **· This paperwork will be completed annually as requested.** **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** **· The Executive Director will be notified of the annual requirement and will be responsible for completion of the appropriate documentation annually.** **· This education will be provided to the new Executive Director by the RVP and / or Designee.** **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** **· The Regional Vice President will audit for the completion of this required form annually and will review the document prior to submission annually as well as with any changes in licensure.** ***By what date will these systemic changes be implemented?*** **· 4-7-12**	

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	the unit provide special safety/security features... yes, Does the Alzheimer's/Dementia care program/unit have activity staff dedicated exclusively to that program/unit... yes..." In an interview 3/7/12 at 9:00 A.M., the Regional Vice President, she indicated the facility had never completed the above document because the entire facility was considered a "Memory Care" unit therefore she did not believe the disclosure needed to be completed.			

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R0144	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to maintain shower grab bars in safe condition for 2 of 14 resident's environment observed out of 56 resident showers. [Resident #44 and Resident #27 showers] Findings include: During the environmental tour of the Trains and Travels neighborhood of facility on 3/7/12 at 9:50 A.M. with the Maintenance Director, in the room for Resident #27, the shower was observed to have a broken grab bar. The grab bar was broken off at the end and when grabbed with hand and weight put onto it, the bar came off of the hinge it was secured to. The Maintenance Director indicated at this time that he had not received any maintenance tickets that informed him that the shower bar was broken. During the tour of the All Sports neighborhood at 10:30 A.M., the room for Resident #44 had a broken grab handle bar in the shower. The end of the grab bar where it was secured to wall was broken and had a jagged edge poking out of the	R0144	**R 144 Sanitation and Safety-Deficiency** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** **The community makes every effort to be clean, orderly, and in a good state of repair, in order to provide a reasonable level of comfort for our residents.** · **Resident # 44: Grab bar in the shower has been repaired.** · **Resident # 27: Grab bar has been repaired.** ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · **The alleged deficient practice has the potential to affect all residents within the community.** · **The Maintenance Director has been provided with information regarding the required preventative maintenance checks of the community.** · **The Maintenance Director will now have a designated binder labeled "Work Orders". As each work order is completed, the work order will be signed by the person completing the repair.** · **Associates have been provided training on how to complete a work order in the event an item in the community is in need of**	04/07/2012

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	bracket that attached it to the wall. During interview with the Maintenance Director at 10:30 A.M. on 3/7/12, he indicated he was not aware that either of these resident rooms had any concerns that needed addressed. At this time, a request of any information or documentation relating to the policy/ procedure related to communication of broken equipment was given. As of exit on 3/8/12 at 4 P.M., no further information was provided.		**replacement or repair.** **· Work order forms will be kept in a designated area of the community in order to document requests by residents and/or family members.** **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** **· The Maintenance Director will now have a designated binder labeled "Work Orders".** **· A manager will be designated to make rounds on a daily basis and report any items in need of repair, utilizing a "work order" form.** **· Other associates will be encouraged to put any findings in writing and place a "work order" request form in the Maintenance Director's Work Order Binder.** **· As each work order is completed, the work order will be signed by the person completing the repair.** **· Work order forms will be kept in a designated area of the community in order to document responses and requests by residents and/or family members.** **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** **· The Executive Director/Designee will audit the work order binder weekly.** **· "Daily rounds" forms will be routed to the Executive Director on a**	

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			weekly basis. · **The Executive Director will be responsible for prioritizing needed repairs.** ***By what date will these systemic changes be implemented?*** · **4-7-12**	

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R0148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to keep the facility free of potentially hazardous materials for residents with confusion. This affected 3 of 14 rooms toured out of a total of 56 rooms in the facility. This had the potential to affect 65 of 65 confused residents residing in facility. [Residents #27, #48, and #33] Findings include: During the environmental tour on 3/7/12 at 9:10 A.M. with the Maintenance Director and the Regional Vice President of Brookdale Senior Living, the Sun Room closet where activities kept knives, and barbeque fork, as well as other sharp	R0148	**R 148 Sanitation and Safety-Deficiency** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** **The community makes every effort to keep the community free of potentially hazardous materials for residents with confusion.** · **The Sunroom closet door has been emptied of any sharp items.** · **Items, such as nail polish, are kept in an area that is out of reach to residents, and accessible only to associates.** · **Resident #27: Disposable razor was immediately removed from the vanity and disposed of in a sharps container located in the secured laundry room. Replacement razor is stored in a locked cabinet in the resident's apartment.** · **Resident # 48: The disposable razor, Body wash and**	04/07/2012

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	items was found unlocked. During an interview at that time, the Maintenance Director indicated the Sun Room closet door should be locked. During the tour of the Collegiate Sports neighborhood at 9:15 A.M., in the kitchenette area there was a bottle of nail polish found in an unlocked drawer. The Maintenance Director indicated at this time, it should not be in an unlocked drawer. During the tour of the Trains and Travel neighborhood at 9:50 A.M., the room for Resident # 27, was found to have a disposable razor in the mirror vanity. CNA #1 indicated in an interview at 9:53 A.M. that the razors are kept in nurses office and then after they are used on a resident, they are to be disposed of in the sharps container which is inside the laundry room that is secured with a keyed entry. She indicated they should not be in the resident's room in the mirror cabinet, if they are in the room they should be kept in the locked cabinet. During the tour of the All Sports neighborhood at 10:55 A.M., the room for Resident # 48, the cabinet in the bathroom was found to be unlocked on one side. Inside the unlocked portion of cabinet within reach there were the following		**shaving cream were placed in a locked cabinet.** **· Resident #33: The two alcohol swabs, medium sized safety pin, 6 tubes of lipstick, and 2 bottles of nail polish were removed.** ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** **· Residents in the community who may not be able to recognize the proper use of personal care items have the potential to be affected by the alleged deficient practice.** **· Associates were re-educated regarding the "Personal Care Items" policy, in order to help them identify items which could present a potential safety risk to such residents. Large quantities of personal care products will be kept in a locked cabinet or drawer.** **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** **· The nurse assigned to each floor of the community will be responsible for completing rounds at the start of each shift in order to audit for compliance with the above policy.** **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** **· Results of audits will be communicated to the Executive Director/Health and Wellness**	

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	items: Disposable razor, 3- 32 oz. bottles of Gillette body wash, which the label indicated "for external use only". One 11 ounce can of shaving creme which the label indicated, "keep out of reach of children". During the tour of the Antique Toys neighborhood at 11:05 A.M., the room for Resident #33, the cabinet in the bathroom was found to be unlocked. Inside the unlocked portion of cabinet within reach there were the following items: 2 -Alcohol swabs, one medium sized safety pin, 6 tubes of lipstick, and 2 bottles of nail polish. The alcohol swabs indicated "Isopropyl Alcohol 70% External Use Only". Upon completion of tour at 11:30 A. M , after discussing the items found in the resident areas, a request was given to the Regional Vice President for the policy regarding personal care items for residents. On 3/7/12 at 1:55 P.M. The following policy was provided. The policy for Resident Personal Care Items dated 11/2011, indicated, "...Some residents are not able to recognize how all personal care items or toiletries are to be properly used. This can include: toothpaste mouthwash, liquid or bar soap, shampoo, cologne, perfume, body splash,		**Director/Designee on a weekly basis.** **· The Executive Director/Health and Wellness Director will take appropriate corrective actions, based on findings. Such action may include counseling, disciplinary action, up to and including termination of the associate responsible, in the event non-compliance is noted.** ***By what date will these systemic changes be implemented?*** **· 4-7-12**	

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	razors, lotions, makeup, shaving cream, nail care items, etc. These items can present a safety risk if they are consumed or used inappropriately. As residents do move freely throughout the community, including into rooms of other residents at times, it is important that all areas of the community are made as safe as possible. This includes bath areas as well as resident rooms Policy Detail Do not keep large quantities of liquid care products out and available to residents where they can mistakenly be ingested. Large quantities of liquid care products...used in the shower room must be stored in a locked cabinet...Tooth paste...makeup, shaving cream, nail care items...on the stop shelf of closet where it is out of view and reach of most residents...All items labeled, 'keep out of reach of children' *and* razors must be stored in a locked drawer or cabinet..." Clare Bridge of Carmel had an admission policy dated 7/2003, which indicated, "...Admission Criteria. The community may admit and retain adults who meet the following criteria: a) Can exhibit signs of confusion and forgetfulness, and behaviors...b) Can exhibit wandering behavior;..."			

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R0154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to keep the ice machine clean for 1 of 1 kitchens. This had the potential to affect 65 of 65 residents that received meals/fluids from the kitchen. Findings include: During the kitchen tour on 3/6/12 at 9:50 A.M., the ice machine was observed to have brown splattered dried liquid on both sides of the inside of the ice machine. In an interview on 3/6/12 at 9:51 A.M., the Director of Dining Services (DDS) indicated he did not know what the dried liquid was. He indicated they clean the ice machine monthly, but he was not certain when it was last done. A request was made for the cleaning schedule for all of the kitchen for February to current date at this time. The DDS provided a cleaning list on 3/7/12 at 10 A.M., there was no task on the list designated for the cleaning of the ice machine. There was no more information	R0154	**R 154 Sanitation and Safety Standards-Deficiency** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · **Ice machine located in the kitchen was cleaned within minutes of the finding.** ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · **In order to prevent an adverse outcome to any residents in the community, the Dietary Manager has provided education to dining staff associates on the methods and standards for appropriate cleaning schedule for the ice machine.** · **The ice machine will be checked for cleanliness every shift and a cleaning "schedule" will be put into place by the Dietary Manager.** **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · **A daily/monthly cleaning chart has been posted at the side of the ice machine.** · **Every four weeks the machine will be emptied, cleaned, sanitized and recorded.** · **These cleaning records will be**	04/07/2012

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	provided as to the cleaning of the ice machine.		**monitored and kept on file by the Director of Dining Services.** **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · **The Dietary Services Manager will provide copies of all audits to the Executive Director on a monthly basis.** · **In the event non-compliance is noted, the Executive Director will be responsible for directing corrective action for the Dietary Department.** ***By what date will these systemic changes be implemented?*** **4-7-12**	

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R0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to obtain the signature of the resident or resident's legal representative on the initial service plan for 1 resident [Resident #35] and an updated service plan for 1 resident [Resident #23]. The deficient practice impacted 2 of 8 residents reviewed for	R0217	**R 217 Evaluation-Deficiency** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · **Resident #35: Responsible party has been contacted to obtain the appropriate signatures on the current Personal Service Plan.** · **Resident #23: A care plan meeting was held with the Health and**	04/07/2012

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	service plans in a sample of 8. Findings include: 1. On 3/7/12 at 1:30 P.M., Resident #35's record was reviewed. Diagnoses included, but were not limited to, dementia, atrial fibrillation, and hypertension. Resident #35's admission or "Move - In" date was 2/10/12. A "Personal Service Plan" dated 2/10/12 did not include a "Signature of Legal Resident/Legal Representative;" however, included "Mailed to Family." On 3/7/12 at 3:45 P.M., the signed personal service plan for Resident #35 was requested from the Health and Wellness Director. In an interview on 3/8/12 at 9:30 A.M. with the Health and Wellness Director, she indicated the facility did not have a signed copy of Resident #35's personal service plan. 2. On 3/6/12 at 12:40 P.M., Resident #23's record was reviewed. Diagnoses included, but were not limited to, heart disease, hypertension, depression, Alzheimer's/Dementia, and diabetes mellitus type II. Admission or "Move - In' date was 1/5/12.		**Wellness Director, Resident Care Coordinator, and the resident's responsible parties. A signature was obtained to indicate their agreement with the current Personal Service Plan.** ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** **· New move-ins who require Personal Service Plans, as well as current residents have the potential to be affected by the alleged deficient practice.** **· Corrective actions will include implementation of a new documentation system, which will allow for the Health and Wellness Director/Designee to bring a copy of the signature page to each Care Plan meeting. Names of all parties attending will be documented in the record. Signatures will be obtained at the time of each meeting and indicated on this page.** **· In the event it is inconvenient for the responsible party to attend a care conference in-person, significant changes and updates to the Personal Service Plan will be discussed via phone with the responsible party, e-mailed or mailed to the responsible party for signature. The disposition for signatures will be noted on the Personal Service Plan.** **· Resident Personal Service Plans completed going forward will utilize the new audit /tracking tool to monitor for completion of the signature page.**	

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	A "Personal Service Plan" dated 2/3/12 was completed related to the addition of home health services. The "Personal Service Plan" included, but was not limited to, "Service Coordination: Resident [#23] is using Physical Therapy services /Occupational Therapy services and Home Health services..." The "Signature of Resident/Legal Representative" was blank. On 3/7/12 at 3:45 P.M., the signed personal service plan for Resident #23 was requested from the Health and Wellness Director. In an interview on 3/8/12 at 9:45 A.M., the Health and Wellness Director indicated the family forgot to sign the new service plan after the care meeting on 2/9/12.		**What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · **In the event the Personal Service Plan has been sent for signature and more than 7 days has elapsed, the Health and Wellness Director / Designee will re-send, and a copy of the documentation reflecting this will be placed in the clinical record file along with the Personal Service Plan.** . **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · **The Health and Wellness Director/Designee will report audit results to the Executive Director/Designee monthly. If additional changes in this system are required, they will be developed and implemented by the QA process of the community.** ***By what date will these systemic changes be implemented?*** · **4-7-12**	

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R0299	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on record review and interview, the facility failed to respond to a pharmacy recommendation to discontinue a medication. The deficient practice impacted 1 of 8 residents reviewed for pharmacy recommendations in a sample of 8. [Resident #23] Findings include: On 3/6/12 at 12:40 P.M., Resident #23's record was reviewed. Diagnoses included, but were not limited to, heart disease, hypertension, depression, Alzheimer's/Dementia, and diabetes mellitus type II. A "Physician's Medication Orders" [MAR] dated 2/22/12 for 3/12 included, but were not limited to, "Mirtazapine 15 milligrams, give 1 tablet orally daily at bedtime as needed for depression/insomnia, start date 1/5/12..." A "Medication Administration Record" dated 1/5/12 included, but was not limited to, "Mirtazapine 15 milligrams... dose given on 1/14/12 at 11:00 P.M. and 1/19/12 at 12:00 A.M.... no doses were	R0299	**Noncompliance** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · **Resident #23: The physician was again shown the pharmacy recommendation, and has signed indicating disagreement with the recommendation.** ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · **Other residents who receive pharmacy recommendations have the potential to be affected by the alleged non-compliant practice.** · **Pharmacy Recommendations will be routinely shared with the physician who is encouraged to indicate whether or not there is agreement with the pharmacy recommendation. The community will continue to routinely share the recommendations and request a signature. What measures will be put in place or what systemic changes will the facility make to ensure the**	04/07/2012

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	recorded on the 2/12 or 3/12 MAR. A "Consultation Report" dated 1/10/12 included, but was not limited to, "Recommendation: Please re-evaluate the PRN [as needed] order for mirtazapine, perhaps discontinuing its use... Physician Response... blank..." In an interview on 3/8/12 at 11:00 A.M., the Health and Wellness Director indicated she gives all recommendations to the physician; however, the physician doesn't always sign them. On 3/8/12 at 2:00 P.M., the facility policy and procedure for pharmacy recommendations and physician notification was requested from the Health and Wellness Director. At that time, the Health and Wellness Director indicated the facility did not have a policy regarding pharmacy recommendations and physician notification.		**alleged deficient practice does not recur? · Nurses have been re-educated on communicating with physicians related to pharmacy recommendations. In some cases, if it is the preference of the physician, these recommendations will be faxed to the physician for a response, and at other times, based on physician preference, the recommendation will be placed in the physician folder in the wellness center, while awaiting a physician decision. · The Nurse Designee will be responsible for following up on any pharmacy recommendations, assuring the response is appropriately documented and the order implemented. · The community no longer employs the services of the physician who neglected to sign the recommendation. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? · The Health and Wellness Director/Designee will audit physician compliance with signing the forms on a monthly basis. The Executive Director will be informed of the results of these compliance audits on a monthly basis. · In the event a physician is**	

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			non-compliant with signing the recommendations, the Executive Director will be notified, and will seek the assistance of the new medical director when indicated. *By what date will these systemic changes be implemented?* · 4-7-12	